

Kaufman Independent School District

Parent/Physician Request for Administration of Medication by School Personnel of NON-prescription medication administered for LESS than 10 (ten) <u>consecutive</u> days.

Student's Name: Birth date:	Date of Requ	:	Grade/Teacher:/										
Fax Number: Phone Number: ****Medication MUST be in Original Container**** Method of administration: () by mouth () inhaled () topical () ear(s) () nasal () gastric tube Time to be Administered:	Student's Name:					Birth date:/							
									Dosage:				
Method of administration: () by mouth () inhaled () topical () eye(s) () nasal () gastric tube Time to be Administered:	Fax Number:					Phone Number:							
Time to be Administered: Dates to be Administered: Condition for which medication is required: Has your child ever taken this medication before? () YES () NO Medication Allergies: () No KNOWN Medication Allergies () Allergic to: Special Instructions/Precautions/Side Effects of medication on your child: Physician's Name: Physician's Signature: Physician's Name: Physician's Signature: Physician's Phone #: Physician's Fax #: My signature below indicates that I request that KISD staff administer the medication specified above to my child, and I am giving permission for KISD staff to contact the physician for additional information, if needed. Parent/Guardian Signature: Email: Parent/Su Daytime Phone: Cell Phone: Medication Count: Cell Phone: <u>Date # Pills Counter's Signature Witness initials Date # Pills Counter's Signature Witness initials Date # Pills Counter's Signature Witness initials Counter's Signature Cell Phone: Entered <u>Date # Pills Counter's Signature Witness initials Date # Pills Counter's Signature Witness initials Counter's Signature</u></u>				***Mec	lication N	/IUST be	in Origir	al Contai	ner***				
Condition for which medication is required:	Method of a	dministra	<u>tion</u> : () by mou	th ()iı	nhaled	() topical () eye(s)	() ear	(s)	() nas	al () gastric tube
Has your child ever taken this medication before? () YES () NO Medication Allergies: () No KNOWN Medication Allergies () Allergic to:	Time to be A	dminister	ed:					be Administ	tered:_				
Medication Allergies: () No KNOWN Medication Allergies () Allergic to:	Condition for	r which m	edication is requ	ired:									
Special Instructions/Precautions/Side Effects of medication on your child:	Has your chil	d ever tal	ken this medicati	on before	?	() YES	()	NO					
Physician's Name: Physician's Signature: Physician's Phone #: Physician's Signature: Physician's Phone #: Physician's Fax #: My signature below indicates that I request that KISD staff administer the medication specified above to my child, and I am giving permission for KISD staff to contact the physician for additional information, if needed. Parent/Guardian Signature:	Medication /	Allergies:	() No KNOWN	Medicatio	on Allergi	es	() Aller	gic to:					
Physician's Phone #:	Special Instru	uctions/Pr	ecautions/Side E	ffects of m	nedicatio	n on youi	child:						
Physician's Phone #:													
Physician's Phone #:	Physician's N	lame:				Phy	/sician's	Signature	:				
Parent/Guardian Signature: Email: Parent/Guardian Signature: Email: Parent's Daytime Phone: x Cell Phone: Parent's Daytime Phone: x Cell Phone: FOR OFFICE USE ONLY! Medication Count: Entered Date # Pills Counter's Signature Witness Initials Date # Pills Counter's Signature Witness Initials Date # Pills Counter's Signature Uitness Initials Date # Pills Counter's Signature Uitness Initials Date													
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			Counter's Signa	ture	Witnes	s Initials	Date	# Pills	Cou				Witness Initials
	Comments (In	dicated b	v * on back of fo	rm).									
					Comments			Date		RN Rev	view		
								_					

Medication Returned to Parent/Student: ______

Date: _____

8/20/2014